



www.mass.gov/dma
www.mahealthweb.com

Date:

Provider Number: _____

Dear MassHealth Provider,

Please supply MassHealth with updated address information by completing the below information. Additionally, any change in your Legal Entity or Check Mailing address must be accompanied by an updated Request for Verification of Tax Reporting Information (W-9) form. If you have a Federal Employer Identification Number (FEIN), you must also attach a copy of your *Notice of New Employer Identification Number Assigned* from the Department of the Treasury, Internal Revenue Service. MassHealth is not able to process changes to Legal Entity or Check Mailing addresses that are not accompanied by a corresponding W-9 form.

Legal Entity Address:

"Doing Business As" Address:

<u>Check Mailing Address (Same as Remit Address on W-9):</u>	<u>Information Mailing Address:</u>

Business Telephone Number: _____

Alternate or Billing Telephone Number: _____

Signature of Provider: _____

Please authorize the above changes with a handwritten signature. In order to expedite the processing of this form, please indicate your provider number in the upper right hand corner.

Completed documents should be returned to:

MassHealth
Provider Enrollment and Credentialing
P.O. Box 9101
Somerville, MA 02145

If you have any questions concerning this information, contact MassHealth Provider Enrollment and Credentialing at (617) 576-4424 or 1-800-322-2909.